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CONTENTS

The "Normality" of the "Psycho Killer"

INTRODUCTION

The "Six O'Clock News" on BBC Radio 4 on 30th October 2003 contained a story, midway through, about the murder of Brian Dodd by Paul Khan. It featured a brief interview with the victim's widow, and reference to the murderer as a schizophrenic who had been released from a secure psychiatric hospital. After hearing the story, I imagined that the following day's newspapers would be full of the details. This is the type of negative story about mental illness that newspapers love: "psycho kills stranger" and "authorities released him to do it".

So it was a surprise to find that only four newspapers included the story on Friday 31st October, and, in all of these, the story was given few words. Why the lack of major headlines or long reports about such a story?

Sadly, it is because such an event - an individual suffering from mental illness who commits a violent act - is seen as "normal". It fits entirely the stereotype of "psychotic = psycho". It is not necessary to report such a story in detail because everybody knows this is what severely mentally ill people do. "They" are dangerous. "Normal people" are not safe. This is an established "fact". Such analysis is simplistic, but it is part of the discourses that establish what is seen as normal in society.

Saying that, it has to be accepted that individuals with mental illness do commit violent crimes, but they "account for a minute proportion of society's violence" (Taylor and Monahan 1996 p967).

Table 1 compares the reporting of the sentencing of Paul Khan by the four newspapers: "Independent", "Daily Telegraph", "Daily Express", and "Daily Mirror".

THE "NORMALITY" OF THE LINK BETWEEN MENTAL ILLNESS AND VIOLENCE

This story appears on the later news pages of all four newspapers, and is reported in no longer than 150 words in length. The average length is 95 words.

Why so few words for such a case? It maybe that this is the sentencing stage, and reports of the trial were more detailed (this was not investigated). None of the other newspapers even mentioned the story.

"The Times" (30/10/03) reports in 39 words on page

	INDEPEN -DENT	DAILY TELEGRAPH	DAILY EXPRESS	DAILY MIRROR
PAGE NUMBER OF STORY	8	11	8	13
NUMBER OF WORDS/LINES (not include headlines)	64/7	144/32	68/13	91/32
HEADLINE LENGTH/ KEY WORDS INCLUDED	8 words/ "Schizo- phrenic"	8/"Freed to kill by doctors"	8/"Freed -to-kill knifeman"	5 "psycho"
DETAILS INCLUDED IN STORY				
- schizophrenic	X	X	X	
- hearing voices		X	X	
- killed stranger	X	X	X	
- "random" attack		X	X	
- after release from secure mental hospital	X	XX	XX	XXX
- stabbed more 30 times	X	X	X	XX
- manslaughter on grounds of diminished responsibility	X	X		X
- age of victim (72)	X	X	X	X

X = reported; XX = more than one reference; XXX = more than two references.

Table 1 - Comparison of main features of reports by four newspapers.

19 about a "paranoid schizophrenic" sentenced for killing someone. Another story that would be expected to produce many words and headlines.

Only the "Daily Mirror" does not include the term "schizophrenic" or "mental illness", but it is clear who is the murderer with reference to "after being released from a psychiatric clinic" (lines 2-4). "Daily Mirror", however, does use the term "psycho" in the headline.

Two newspapers that did not report this story on 31/10/03, the "Daily Mail" and the "Guardian", reported at length the case of another similar murder. The case of Michael Little was given the whole of page 29 (approximately 350 words with photographs) in the "Daily Mail", and approximately 800 words (with photographs) on page 6 of the "Guardian". This story contained the headlines I would have expected for Paul Khan's case:

Daily Mail - "'This monster has taken the meaning out of our lives'"

Guardian - "'Violent loner' with 'crazy artist' delusions stabbed young cabaret dancer"

It seems that Michael Little had not been in a psychiatric hospital, nor been given an "official" diagnosis of mental illness. He is described as a "weirdo" and a "loner who never had a girlfriend" in the "Daily Mail". Within the traditional stereotype of mental illness that is enough for him to be dangerous. Mental illness means weird. This is a murder of a young woman, and Paul Khan murdered an older man. Both are murders, yet one is given extensive coverage, and the other not (other newspapers also reported the Michael Little case in detail).

To the stereotyped eye, both crimes are the same: "odd person" murders stranger. The difference with the Michael Little case is that the victim is a young female, and thus much more newsworthy than a "pensioner". Sadly, news value is placed upon such factors. The murder of a 72-year-old man is bad, but not as bad as that of a 21-year-old woman. Yet in reality, there are both murders of the same type, and equally shocking.

It should also be noted that Little hid the body in a cupboard, and such details of murder are assumed to "fascinate" readers compared to a straightforward stabbing.

Overall, we can say that weird or odd means mental illness, whether the individual has been diagnosed as such or not. And the link between mental illness and violence is seen as "normal", and thus not even really newsworthy. It is "old news".

A certain bias to reporting of mental illness has led to the creation of this particular "normality". Greg Fillow (1995) noted the overemphasis on violence, and the stereotyping of the "mad axe-person". Also terms, like "paranoid schizophrenia" are used in non-technical ways, and linked to the negative impression.

Scheff (1966) goes further:

> Even if the coverage of these acts of violence was highly accurate, it would still give the reader a misleading impression because negative information is seldom offset by positive reports. An item like the following is almost inconceivable: Mrs Ralph Jones, an ex-mental patient, was elected president of the Fairview Home and Garden Society.. (p72; quoted in Miles 1987).

A MORI survey for BBC ("Don't Fence Me In" 1995) found that a majority of those questioned felt that individuals with mental illness were more likely to

commit violent crimes.

The perception of "violent psychosis" has increased over time. A survey of adults in the USA in 1950 found that 7.2% mentioned violence in relation to mental illness. This figure was 12.1% in 1996 (Phelan et al 2000). While 71% of a UK sample attached "dangerous" to schizophrenia (Yarney 1999).

The negative stereotype of mental illness is reinforced throughout the media. Wilson et al's (2000) study of children's television in New Zealand found it littered with negative terms, like "crazy", "loony", and "wacko". The researchers believed that young viewers "are being socialised into stigmatizing conceptions of mental illness" (p440). While "Bollywood" films in India present mental illness as comedic or slapstick, and not in a sympathetic light (Bhugra 2000).

The existence of negative stereotypes is very important because it influences how the individual feels about themselves when given such labels, and how society responds to such individuals. The "Rethink Just One Per Cent" report (2003) noted that 28% of individuals with severe mental illness had been "shunned when seeking help" in the last three years.

Legge (2002) is clear about the role of the stereotyping:

> The "dangerous mental patient" is in fact nothing more than a social stereotype. It fulfils the same role that the "lazy, ignorant negro" did in the southern states of the USA or that the "sly, dishonest jew" did in nazi Germany. It is a piece of politically motivated bigotry (p9).

BLAME THE AUTHORITIES

In the Paul Khan case, the newspaper reports, though short, make it clear that he had been released from a psychiatric hospital. Here is someone to blame - the mental health professionals who freed an "obvious killer".

> Daily Telegraph - "He was supposed to be held indefinitely for the earlier attack but was released in August 2000 after a tribunal decided he could be cared for in the community" (lines 11-16)

> Daily Express - "..in 1996 Khan was detained indefinitely after slashing another stranger's throat but was released back into the community four years later by a mental health

professionals (sic)" (lines 8-13)

Daily Mirror - The victim's widow said: "The people who agreed to discharge him are as much to blame as Khan" (lines 21-23)

"The Judge.. said the order detaining him indefinitely had 'manifestly failed'" (lines 28-32)

It is not a question of whether Khan should have been released from a secure psychiatric hospital, and this is a difficult question. It is the question of who to blame, and that those blamed should have known: "Mrs Dodd said: 'This is a crime which could have been prevented'" (Daily Mirror lines 18-20). The ability to say after the event that something could have been predicted at the time is known as the hindsight bias or effect.

The other aspect here is the belief that certain individuals should never be released from secure psychiatric hospitals. The inevitability of re-offending is not the case. Jamieson and Taylor (2002) report the twelve year follow-up of 198 individuals released from Broadmoor, Ashworth, and Rampton special hospitals in 1984. Of those individuals, 22% spent time in prison, and 19% were readmitted to a special psychiatric hospital. Twelve years after release, 78% were living in the community. It should be pointed out that we are talking about special psychiatric hospitals here, which are for individuals who commit crimes. This is entirely different to the majority of those with mental illness, who do not commit crimes.

The assessment of future risk is difficult in any area of psychology and psychiatry. The ability to do this successfully for any behaviour is the goal of many psychologists and psychiatrists. Predicting the future exactly is unlikely to be achieved, and so probabilities and likelihoods are important.

Psychiatrists will assess the potential risk factors, like the nature of any delusions or past violence, before making a decision about the release from hospital of individuals with mental illness (table 2). It is not an exact science. Often the risk assessment proves to be correct, but this is rarely reported - "patient released from Broadmoor does not commit crime".

Sadly when it is wrong, it makes headlines because of the consequences. Realistically, who can predict absolutely what they will do in the future, let alone another person?

However, the need to blame someone is also a

1. Active psychotic symptoms and substance abuse and history of violence or current hostile attitudes

2. "Threat/control override" (TCO) symptoms - delusions of being threatened or controlled by outside forces

3. Delusional beliefs about significant others - for example, that they are imposters

4. Hallucinations to commit violence or self harm

5. Erotomania with multiple delusional objects (ie: focus of obsession as in stalking behaviour) and history of serious anti-social behaviour unrelated to delusions

6. Narcissistic injury (self harm), isolation of affect (lack of appropriate emotional responses in situations), threatening behaviour, and availability of weapon

(After Litwack and Schlesinger 1999)

Table 2 - A number of different risk factors for violence among individuals with mental illness.

construction of this society. There is a contradiction between the need to find someone to blame ("blame culture") and the "individualism without responsibility". For example, after a rail crash, there is the search for who caused it. Yet if certain advice is given beforehand, individuals would reject it as to "Nanny-State". Individuals are free to choose their destiny, not the State, but when it goes wrong, the State is responsible.

THE INDIVIDUAL WITH MENTAL ILLNESS

I (Brewer 2002) noted, in the case of a man with a Personality Disorder who committed suicide, the need to place responsibility for the event on someone. There was little attempt to understand why the individual had killed himself, other than to refer to his Personality Disorder. The same is the case with Paul Khan - no attempt is made to understand why he murdered the victim. The only explanation is that Khan was schizophrenic and was "hearing voices".

This does not explain the motivation of the killer nor anything about them as an individual. What about the mental distress that led to such behaviour? It is important to emphasise that looking for explanations for extreme behaviour, or trying to understand their behaviour, is not, in any way, justifying their behaviour. But they are many people with schizophrenia and/or hear voices who do not murder a stranger.

There is an individual behind the crime, however horrific that crime. Hartley (2002) points out that a mental patient is not seen as a "real person". This

partly explains the need to hold someone else accountable when things go wrong.

Legge (2002) goes further:

> The illusion that a person ceases to exist as a moral agent, responsible for their own behaviour once a psychiatric diagnosis such as "schizophrenia" has been made is perhaps the most alarming outcome of all this "misinformation". People now believe in the existence of "schizophrenics" as people believed in "witches" four hundred years ago (p10).

NEWSPAPERS

Daily Express, 31/10/03, "Freed-to-kill knifeman gets a life sentence", p8

Daily Mail, 31/10/03, "'This monster has taken the meaning out of our lives'", p29

Daily Mirror, 31/10/03, "Psycho in jail for life", p13

Daily Telegraph, 31/10/03, "Life for man freed to kill by doctors", p11

Guardian, 31/10/03, "Body in cupboard killer jailed for life", p6

Independent, 31/10/03, "Schizophrenic who stabbed man is jailed for life", p8

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Mechanisms of Defence

BASIC FUNCTIONS AND MANIFESTING LEVELS OF DEFENCE

The concept of defence is defined by Freud as:

> The ego makes use of various procedures for fulfilling its task, which, to put it in general terms, is to avoid danger, anxiety and unpleasure. We call these procedures "mechanisms of defence" (Freud 1937 p235).

Therefore, in terms of Freud's structural model of psychic personality (1964/1933), Freud presents these unconscious mechanisms as mediating compromises between the Id's instinctual impulses and the demands of external reality (as perceived by the Ego and influenced by the moral injunctions of the Superego) in order to maintain homeostasis of the psyche. This reflects the idea of classical, traditional psychoanalysis, which "views defences primarily from a predominantly intrapsychic perspective" (Bateman and Holmes 1995 p76).

Later ideas about defences, which applied an object relations approach (ie Melanie Klein), suggest that "very primitive, pre-verbal defence mechanisms exist...which serve to rid the mind of unbearable affects and experiences and evoke these in the mind and behaviour of another" (Chadd 2002). This approach therefore emphasises defensive functions on a more interpersonal/relational level.

From a socio-biological/evolutionally perspective, this emphasis is natural because of the underlying assumption that human beings are innately programmed "as people seekers who need to be attached to, confirmed by and communicate with other human beings" (Thomas 1996 p306).

Frosh (1991 cited in Morgan and Thomas 1996) added that we are essentially driven by unconscious dynamics resulting from the mutualistic internalisation of mental objects/relations from inter-subjective experience and because of this, "the real turmoil in the outside world is mirrored internally" (Thomas 1996 p327), thus reflecting a cycle of interaction between interpersonal back to intrapsychic defences.

To summarise so far, defences are employed as a way of avoiding psychic pain and maintaining homeostasis; these can manifest themselves intra-psychically (classical psychoanalysis), interpersonally/relationally (object relations; socio-biological approaches) and as an

interaction of the two (Frosh 1991 cited in Morgan and Thomas 1996; object relations).

CLINICAL INTERPRETATION OF DEFENCES (DEVELOPMENTAL, PATHOLOGICAL AND ADAPTIVE)

It is possible to differentiate defences in terms of their link with "childhood psychological functioning to emotional difficulties in adulthood (Bateman and Holmes 1995 p80) (table 1). In principle, the more mature the defence, the more adaptive it is for making successful life adjustments.

PRIMITIVE/IMMATURE	NEUROTIC	MATURE
Autistic phantasy	Condensation	Humour
Devaluation	Denial	Sublimation
Idealisation	Displacement	
Passive-aggression	Dissociation	
Projection	Externalisation	
Projective Identification	Identification with Aggressor	
Splitting	Intellectualisation	
	Rationalisation	
	Reaction formation	
	Regression	
	Repression	
	Reversal	
	Somatisation	
	Undoing	

(After Bateman & Holmes 1995)

Table 1 - Mechanisms of Defence.

The simple underlying explanation of how such mechanisms arise in the first place is that we are required to face certain psychological challenges (eg: Oedipal struggle against same sex parent to attain love of opposite sex parent as part of the process of gender identification) at (1) different stages (1) in normal personality development, and (2) as we face different acute and chronic emotional traumas from adolescence onwards.

This involves the complex interaction between an individual's intrapsychic needs and desires, and whether these are satisfied by relationships etc. with the outside world (particularly by parents). When these needs are unfulfilled consistently or traumatically, the psyche needs to protect itself from the associated pain so develops defence mechanisms, which serve to reframe similar events cognitively and emotionally to prevent future experiences of that type being processed in such a painful way; meanwhile, the pain and emotions from the

original experience triggering the defence remain and are usually suppressed in the unconscious.

Primitive defences (20, which arise very early in development therefore, are used to defend against very early infantile anxieties derived from the death instinct (thanatus) associated with destructiveness and persecution; eg: expulsive defences such as projection. The later manic defences (3) are associated with the depressive position where the infant has to fuse the good and bad parts of their internal objects together and defend against libido; much of Klein's work has focused on the former of the two.

It is important to keep in mind that defences can be normal and adaptive in function (ie humour & sublimation), as well as pathological. Successful defences allow the expression of instinctual drives in contrast to unsuccessful ones, which "fail to do this thus necessitating their continuous repetition" (Kline 1972 p151).

In addition, Garland (1991) argues that primitive defence mechanisms in psychologically healthy individuals can emerge as a result of exposure to extreme stress, but these only become maladaptive if they become increasingly habitual and rigid.

Some proponents within cognitive psychology (eg Horrowitz et al 1990) also argue that defence mechanisms can be adaptive as well as maladaptive, construing them as the "outcome of cognitive control processes which sequence ideas and join meanings together" (Bateman and Holmes 1995).

In addition, Malan argues that "behaviour" arising from the engagement of defences "often has an expressive as well as a defensive function, containing the avoided feelings or impulses in a disguised form" (Malan 1995 p15); this is particularly characteristic of the defence of sublimation.

HOW DEFENCES CAN BE APPROACHED THROUGH THERAPEUTIC WORK

Brown and Pedder (1991) describe how the therapists' approach to defences will change as the therapeutic relationship changes. Therefore, at Cawley's (1977) outer level of psychotherapy, defences are supported and reinforced; as these progress to deeper levels (and as ego strength increases); ie: exploration, these defences are confronted and modified. A cognitive therapist may also approach defences with a view to modifying them or developing them, but at a cognitive level.

More recent developments in psychotherapy in the

area of Cognitive Analytic Therapy (CAT) perceive "'defence[s]'...to be the result of inadequate higher-order, integrative functions and is dealt with by strengthening those functions through reformulation in the context of the therapeutic relationship (Ryle 1990 p216).

It is hoped that through the safe inter-penetrable structure of the therapeutic relationship that the individual unconscious conflicts can be acted out and resolved. However, it is also the case that the heightened expressions of defences are often due to the deterioration of boundaries evoked by therapeutic participation, which induces feelings of vulnerability, arousing infantile anxieties and transferences reminiscent from experiences of early relationships.

Now that the underlying principles of defence mechanisms have been reviewed, the remainder of this article will summarise a few common defences in terms of their relevance to therapeutic practice.

DISCUSSION OF SOME COMMON DEFENCE MECHANISMS

Displacement through the Transference Relationship

"When we are too afraid to express our feelings or affects directly to the person who provoked them, we may deflect them elsewhere" (Bateman and Holmes 1991 p29); this process of defence is known as displacement.

"Freud spoke about transference as a photographic plate projected on to the analyst" (Symington 1986 p111). Using Malan's (1995) triangles (4) as a way of conceptualising such projections; ie: the defences against how the "other", makes you feel in the past, the present will also be exhibited with the therapist. This is particularly useful when clients exhibit a covert defence within the therapeutic relationship, such as displacement.

In addition Winnicott argues that "Full analysis of the transference gives analysis of the inner reality. But an understanding of the latter (5) is necessary for a clear understanding of the transference (Winnicott 1975 p132). King (1978) also directs us to analyse our counter-transference in the therapeutic relationship, advising that "it is often possible to find a clue to such unconscious communication in his own [the therapists] affective response to the patient's behaviour" (Casement 1985 p83).

Overall this highlights the need for careful attenuation to such projections, as in the absence of

this, the therapy can become stuck and at times counterproductive.

Phobic Avoidance

Phobic avoidance (listed as a defence in Brown and Pedder 1991) is a conscious, defensive behaviour that manifests itself in order to prevent the arousal of unconscious psychological pain associated with the stimulus being avoided. Although, in the traditional sense, it is often not perceived as a "defence" per se in the literature, it is indeed a very common mechanism of defence (with maladaptive consequences for those who exhibit it). It is interesting that in clinical practice, it is probably the only defence that is referred for treatment and specified as "the problem"! We don't see many (if any) referrals asking us to treat someone with displacement for example. Perhaps it is because these other defences are perceived more as part of an individual's personality, rather than focusing on its external behavioural manifestation.

Sublimation

Hinshelwood describes sublimation as "the healthy discharge of instincts in mutated form through socially accepted, and socially provided, channels (Hinshelwood 1998 p130). Hinshelwood (1998) also describes how Klein saw this as reparation embodying the "sublimation of guilt into constructive action" (ibid p130).

Examples of sublimation can be seen everywhere in our popular culture. For example, the musical lyrics of Eminem, the tortured poetry of Sylvia Plath and the artistic creations of numerous artists who Kline (1972) suggests are sublimating anal expulsive tendencies with paint as an acceptable pleasure in unconscious substitute for the faeces; the examples are endless. It is also notable that through the placing of such works in the public domain (through performance and exhibition), the creator is receiving mass validation for their feelings, although there is always the danger that negative criticisms of their work could further reinforce the painful feelings they were trying to defend against in the first place (ie if the painful feeling was rejection).

In terms of therapeutic work, it can be useful to explore a client's inner creative life (ie fantasies, dreams) and ways in which they externally employ creativity (eg hobbies). It is also interesting to consider how this defence has been exploited in a

positive way in psychologically therapeutic contexts; eg: Narrative, Art and Music Therapies.

However, overindulgence in this defence can have problematic consequences. An example of this was exhibited by a client (6) I saw for therapy who used creative writing within the horror genre to sublimate his anger. Despite these stories sounding quite horrific, the client never appeared to be a threatening individual and their writing especially, offered them a safe avenue to explore their anger without causing pain to others. Ironically though, the more the client slipped into this defence, the greater their fear became of losing control over his anger as it became catastrophised through the medium and also, failed to allow them to desensitise themself to "expressing" anger directly to others in order to challenge their distorted cognitions of being unable to control this expression.

Splitting and Reaction Formation

Splitting is one of the early primitive defences which is used by the infant during their development in order to defend against the confusion, frustration and ambivalence caused by the mixed levels of satisfaction towards the mother. Because the mother can never be a perfectly satisfying object, the infant is faced with two conflicting positions of a mother who is loved but also hated. To defend against this, the infant internally splits the mother object into good and bad part objects so as to avoid damage to the good part; this is crucial since contamination of the good object would result in the infant having to reject the whole object. These objects are later fused in the depressive position.

Reaction Formation is when "an individual adopts a psychological attitude that is diametrically opposed to his conscious wish or desire" (Bateman and Holmes 1991 p88). For example, Freud (1915 cited in Kline 1972) specified a change from active to passive (eg: sadism to masochism) and reversal in content (eg: love to hate).

It is valuable to add that clients who exhibit splitting and reaction formation (eg: Borderline Personality Disorder) are often challenging to work with as these defences foster dichotomous thinking which is resistant to change. For example, where a client's perceptions of good and bad are split, those who are good are portrayed in an idealised way and those who are bad tend to be described with no good qualities, with no grey area in between for compromise. Clients who think and feel in these ways also find it difficult to integrate good and bad within their internal object

representations and instead split them, maintaining the image that was less painful. This leaves the client in a psychological position where they remain trapped in Klein's Schizoid-Paranoid Position (ie split) and unable to progress to reaching the Depressive Position (ie the healthy integration of good and bad).

Repression -"The Classical Primary Mechanism of Defence" (Bateman and Holmes 1991)

Freud (1915 cited in Kline 1972) describes repression as "the essence of repression lies simply in the function of rejecting and keeping out of consciousness" (p151). As a result, wishes that are incompatible with reality, superego demands or other impulses remain unconscious. There are two types of repression in classical psychoanalysis; "primal repression" which denies entry of the mental representation of an instinct into consciousness.

Repression proper concerns the expulsion of mental derivatives and associations of the repressed representation. The mental energy belonging to the repressed instincts is then transformed into affect; ie: anxiety. If this defence persists into later life, it can lead to "marked dissociation of whole areas of emotional life from consciousness" (Bateman and Holmes 1991 p88), which can become extremely maladaptive and in severe cases, manifest itself as difficulties with dissociation within the personality (eg: Dissociative Identity Disorder) and in cognitive functioning within the memory system.

CONCLUSION

To conclude, defences are common phenomena arising through life experience as we progress through stages of personality development (although they can be triggered later in life through trauma); either way, their purpose is the same: to avoid us experiencing further psychological pain.

In terms of therapeutic practice, knowledge of such defence mechanisms in understanding clients' presentations and relationships with others, including the therapeutic alliance has been invaluable. However, it has also been crucial during therapeutic work to attenuate to the ego strength of the clients and consider Brown and Pedder's (1990) advice regarding the tasks at different levels of therapy when working with defences.

FOOTNOTES

1. Freud's psychosexual stages; Klein's different positions; Erikson's life stages.

2. Also referred to as psychotic (the depressive and paranoid-schizoid positions) in Kleinian terminology.

3. Also referred to as "neurotic" (as in Table 1).

4. Two triangles, one upright and one inverted side by side. One has Patient, Therapist and Other on each corner, and the other has Anxiety, Hidden Feeling (the feeling(s) being defended against) and Defences on each corner. Both triangles reflect how all of these aspects interact between all of the elements and the settings in which the individual exhibits their defences. This is a conceptual framework used to formulate individuals' difficulties within the psychodynamic paradigm.

5. Winnicott is referring to the concept of the manic "defence" when he uses the term "latter" but in this instance, it has been generalised to mean defences.

6. This client has given their permission to be used in this publication. However, their details have been changed to preserve anonymity.

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